

**Thrive OT Referral Form**

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| Patient Information |
| Patient Name:NHI#:ACC Claim #: | Referrer’s name |
| DOB | GP Name |
| Address | Practice Address |
|  |  |
| E-mail | Phone |
| Phone | Fax |
| Brief Medical and Social History | Medications(if relevant. e.g. psycho-active/analgesic) |

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| Reason for Referral for Occupational TherapyTICK TICK |
|  | Home Environment Assessment |  | Wellness Management: healthy routines/habits e.g. exercise, sleep, eating habits, stress management etc |
|  | Falls Prevention Intervention |  | Engagement in meaningful activity/Problem solve barriers to participation |
|  | Independence and Safety training e.g.: performing daily tasks in home/community |  | Role Transition. e.g. Retirement, caregiver, dependent, loss of drivers license |
|  | Community Participation/Socialisation |  | Work/Productivity |
|  | Education in strategies: fatigue/pain, stress/anxiety, managing disability etc |  | Other |
| Other Relevant Info.Expected Outcome: |

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| Funding Source (please circle applicable source)  |
| Patient Privately Pays | Acute Demand/ Care Plus/ |